

[illegible]

ALLERGY	MURDA				NURSE'S SIGNATURE		INITIAL	NURSE'S SIGNATURE		INITIAL
DIAGNOSIS					NURSE'S SIGNATURE		INITIAL	NURSE'S SIGNATURE		INITIAL
PHYSICIAN NAME	D. Spaigner CRNP				PHYSICIAN PHONE NO.			PHYSICIAN PHONE NO.		
FACILITY NAME	HAT				SECTION			ROOM NO.		
PATIENT NAME	Rhodes				PATIENT NO.		46930	PATIENT NO.		46930
					NURSE'S SIGNATURE		INITIAL	NURSE'S SIGNATURE		INITIAL
					NURSE'S SIGNATURE		INITIAL	NURSE'S SIGNATURE		INITIAL

[illegible]

NURSES
NOTES

HOUSTON COUNTY JAIL MEDICAL CLINIC

INTAKE

DATE 5-2-05

INMATE Rhodes George# 57322 DOB 4-6-65

ALLERGIES NKDA

VIS 107/71 58 98.8

HEIGHT 5' 9" WEIGHT 159

02 = 98%

CURRENT MEDICAL PROBLEMS

HTN since 1998, Angina & palpitation
since 1998.

PERSONAL DOCTOR Dr. Baker @ SEAMC ADDRESS
Dr. Pinson - cardiologist

HOSPITALIZATIONS

12-2004 - SEAMC

King's County Hosp. New York - for chest
pain in 1998

CURRENT MEDICATIONS

Atenolol 25mg, ASA 81mg → Walgreen's on
last dose Thursday 4/28/05 Westgate

MEDICATIONS BROUGHT IN? (NO)

NURSING ASSESSMENT:

BM c & distress.

SEAMC = release sign

3/ LA (nurses initials) EXPLAINED HOW TO OBTAIN MEDICAL
TREATMENT WHILE IN HCJ

NURSE

U Hathaway

LABS / XRAY S

PLEASE
DO NOT
STAPLE
IN THIS
AREA

NURSING
Case 1:06-cv-00305-WHA-SRW
HOUSTON COUNTY SHERIFFS
PO BOX 6406
DOTHAN, AL 36302

4207-0100-0100 Document 14-7 Filed 06/23/2006

PAGE 1

Page 10 of 57

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input checked="" type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 136604317	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) RHODES, GEORGE		3. PATIENT'S BIRTH DATE MM DD YY 04 06 1965 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street) HOUSTON CO JAIL		7. INSURED'S ADDRESS (No., Street) RHODES, JR GEORGE HENRY	
CITY DOTHAN		CITY DOTHAN	
STATE AL		STATE AL	
ZIP CODE 36301		TELEPHONE (INCLUDING AREA CODE) (334) 794-5424	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) N/A		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER Immature		12. INSURED'S DATE OF BIRTH MM DD YY <input type="checkbox"/> M <input type="checkbox"/> SEX <input type="checkbox"/> F	
13. EMPLOYER'S NAME OR SCHOOL NAME		14. INSURANCE PLAN NAME OR PROGRAM NAME	
15. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.		16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE	
17. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 05 10 06		18. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 05 10 06	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE SAMMY R BANNER		20. I.D. NUMBER OF REFERRING PHYSICIAN E01167	
21. RESERVED FOR LOCAL USE		22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 719 45		24. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
25. MEDICAID RESUBMISSION CODE		26. PRIOR AUTHORIZATION NUMBER	
27. DATE(S) OF SERVICE From MM DD YY To MM DD YY		28. PLACE OF SERVICE B	
29. TYPE OF SERVICE C		30. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
31. DIAGNOSIS CODE 1		32. \$ CHARGES 368 00	
33. DAYS OR UNITS 1		34. EPSDT Family Plan 1	
35. EMG 1		36. COB 1	
37. RESERVED FOR LOCAL USE		38. RESERVED FOR LOCAL USE	
39. FEDERAL TAX I.D. NUMBER 630577764		40. SSN EIN <input checked="" type="checkbox"/> X	
41. PATIENT'S ACCOUNT NO. 2777788X1		42. ACCEPT ASSIGNMENT? (For govt. claims see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
43. TOTAL CHARGE \$ 368.00		44. AMOUNT PAID \$	
45. BALANCE DUE \$ 368.00		46. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # RADIOLOGY ASSOCIATES OF DOTHAN 2015 ALEXANDER DR DOTHAN AL 36301-3003 334-671-1696	
47. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) CHARLES H HOLLOWAY MD 05/16/06		48. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) SOUTHEAST AL MEDICAL CTR 1108 ROSS CLARK CIRCLE DOTHAN AL 36301	
49. SIGNED CHARLES H HOLLOWAY MD		50. DATE 05/16/06	

**Actus Radiology Workstation Report**Management Services Network
SE Alabama Medical Center

Lifecode Date: 05/12/2006 ■

DocID: 71484578 [4]

■ Document Status: Acceptable

Patient Information

Patient Name: RHODES, GEORGE

Date of Service: 05/10/2006

Payer Class: Comm

MRN: 000400545

Place of Service:

Payer Code:

Account: 2777788

Site Code:

Client Status: Normal

Age: 41 year-old Gender: Unknown

Physician: Hugh Holloway, MD

Phy. Code: 07

DOB: 04/06/1965

Referring Physician:

Ref. Phy. Code

ICD-9-CM**Code Description**

1. 719.45 Pain in joint involving pelvic region and thigh
- 2.
- 3.
- 4.
- 5.

CPT/HCPCS II

CPT only © 2004 American Medical Association. All Rights Reserved.

Code Modifier Units ICD-9 Description

- | Code | Modifier | Units | ICD-9 | Description |
|----------|----------|-------|-------|--|
| 1. 73720 | 26 | | 1 | Mri, lower extremity other than joint; w/o contrast matl(s), followed contrast matl(s) f |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
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| 11. | | | | |
| 12. | | | | |
| 13. | | | | |
| 14. | | | | |
| 15. | | | | |

Review Flags / Ancillary Information**Warning****Informational**☐ ICD-9 Review☐ No Reason for Exam☐ Resident Involved☐ Interventional☐ CPT Review☐ No Covered Diagnosis☐ Oncology☐ Physician NR☐ Other☐ Nuclear Medicine☐ Possible Unbundling☐ Ultrasound**Review Reason****Coder Comments**

<LCI>

MRI MRI LOW EXT WO/W RT

Page 1 of 2

PO Drawer 6987, Dothan, AL 36302

334-793-8111

RADIOLOGY SERVICES

MRI REPORT

Patient Name: RHODES, GEORGE

XRAY/MR#: 000400545 Account #: 2777788 Room:MI- -

DOB: 04/06/1965 Age: 41 Pt Type: O

Order #: 00127777888379206 Accession #: 001000000154472

CDM: 3836172

Attending Physician: Sam Banner, MD

Ordering Physician: Sam Banner, MD

Referring Physician: Sam Banner, MD

Exam Requested: MRI LOW EXT WO/W RT

Exam Date: 05/10/2006

</LCI>

PROCEDURE: MR RIGHT FEMUR W/O AND W/GADOLINIUM

HISTORY: RIGHT HIP PAIN AND SWELLING SINCE 2/11/06. PATIENT FELL AND

HURT RIGHT HIP ON 2/11/06.

COMPARISON: PLAIN RADIOGRAPHS 4/4/06

TECHNIQUE: PATIENT STUDIED WITH AXIAL, CORONAL AND SAGITTAL T1 AND STIR

SEQUENCES. IN ADDITION POST GADOLINIUM FAT SUPPRESSED

CORONAL AND AXIAL T1 WEIGHTED SEQUENCES PERFORMED.

FINDINGS:

There is a large mass-like area involving the right upper thigh which is slightly hyperintense to muscle on T1 and is markedly hyperintense on T2 and has internal areas of mixed signal. Associated with this is abnormal marrow signal in the region of the greater trochanter of the femur and extending slightly into the intertrochanteric area. Review of the plain x-ray from 4/4 shows some soft tissue calcification.

Following Gadolinium administration there is abnormal enhancement evident within the periphery of the soft tissue of the mass as well as some abnormal enhancement within the intertrochanteric portion of the femur itself.

Continued..

The mass-like area mainly is involving the area of the vastus lateralis but near the upper thigh is almost completely encircling the femoral shaft. Main considerations particularly given the history of pain the abnormal soft tissue calcification and the appearance of the mass with the abnormal Gadolinium enhancement is that of some type of chondrosarcoma. Other considerations include osteogenic sarcoma or much less likely a stress fracture of the femur with associated myositis ossificans. Patient incidentally appears to have some small inguinal lymph nodes bilaterally.

IMPRESSION:

1) LARGE MASS MEASURING APPROXIMATELY 13 X 9 X 8.5cm WHICH HAS ASSOCIATED SURROUNDING EDEMA IN THE SOFT TISSUES OF THE THIGH AS WELL AS ABNORMAL MARROW SIGNAL IN THE GREATER TROCHANTERIC REGION OF THE FEMUR. THIS IS SUSPICIOUS FOR ENTITIES SUCH AS A CHONDROSARCOMA, OSTEOGENIC SARCOMA OR LESS LIKELY A MALIGNANT FIBRO-CYSTICOTOMY. STRESS INJURY TO THE FEMUR WITH ASSOCIATED MYOSITIS OSSIFICANS MIGHT POSSIBLY GIVE THIS APPEARANCE BUT IS FELT LESS LIKELY GIVEN THE MARKEDLY ABNORMAL ENHANCEMENT PATTERN IN THE PROXIMAL FEMUR.

<LCI>

Hugh Holloway, MD

IN Make
Request

INMATE REQUEST FORM

Date: May 8, 2006 INMATES # 57322 M8
To: INMATE C/O SIGNATURE CHK. name
From: George Rhodes SR C/O SIGNATURE _____

NATURE OF REQUEST

I have an emergency today due to pain traveling
down to the lower extremities of my right leg.

After speaking with Co Morrison I was informed that Medical
wished for me to fill out a request form that shall be received
the next day.

ACTION TAKEN

LN PN

INMATE REQUEST FORM

Date: 04.24.06 INMATES # 57322 M8To: Clinic C/O SIGNATURE anyFrom: George H. Rhodes, Jr SR C/O SIGNATURE Sgt. Marsh

NATURE OF REQUEST I AM EXPERIENCING PAIN BOTH DURING THE DAY & NIGHT TO THE POINT IT HAS BECOME UNBEARABLE. THE 10mg FLEXARIL MUSCLE RELAXER IS NO LONGER WORKING & NEED SOMETHING STRONGER LIKE PAIN KILLERS. THANK YOU VERY MUCH.

ACTION TAKEN

DR B. Can take guards
Tylenol from guards
until MRI & results.

INMATE REQUEST FORM

Date: 02018006 INMATES # 57322
 To: Clinic C/O SIGNATURE [Signature]
 From: George Rhodes F-POD SR C/O SIGNATURE [Signature]

NATURE OF REQUEST On February 11, 2006 I slipped & fell while taking a shower & sustained an injury to my right hip where the area is now swollen causing major pain while sleeping.
Thank you very much for your time & consideration.

ACTION TAKEN

Southeastern Printers / Form #5135 / Rev 3-98

INMATE REQUEST FORM

Date: 03025006 INMATES # 57322
 To: Clinic C/O SIGNATURE [Signature]
 From: George Rhodes F-POD SR C/O SIGNATURE [Signature]

NATURE OF REQUEST I AM requesting a medical appointment for either an X-ray or MRI scan to address the excruciating pain in my right thigh because the prescription for the muscle relaxer has ceased.

Furthermore, I would like to get to the bottom of this issue.

ACTION TAKEN Thank you very much!

PULL C!

INMATE REQUEST FORM

Date: July 13, 2005 INMATES # 57322
To: NURSE / INFIRMARY C/O SIGNATURE _____
From: George Rhodes F-8 SR C/O SIGNATURE 8
NATURE OF REQUEST I was informed by C/O Neives to fill out this form to make arrangements for finger nails to be clipped. Thank you in advance regarding this matter.

CC: File

ACTION TAKEN

done

INMATE REQUEST FORM

Date: 8/23/05 INMATES # 57322
To: Infirmary C/O SIGNATURE Ch R. Moore
From: George Rhodes F-POD SR C/O SIGNATURE _____
NATURE OF REQUEST I am requesting to have my 4⁰⁰ AM meds changed to the afternoon for the sole purpose of gaining proper rest and avoid mental fatigue throughout the course of the day. Thank You!

ACTION TAKEN

Referral?

**HOUSTON COUNTY JAIL
INFIRMARY
901 EAST MAIN STREET
DOTHAN, ALABAMA 36301**

SECTION 1 TO BE COMPLETED BY CORRECTIONAL FACILITY

Inmate referred to : (Name & Address) <i>outpt Radiology</i>		Reason for referral: <i>CRNP order - (see enclosed)</i>	
Appointment Date <i>4/4/06</i>	Appointment Time	Date of Birth <i>9-16-65</i>	Social Security #
Inmates Name: <i>Rhodes, George</i>		Additional Health Info. :	

Reason for Referral :

Deputy Required yes () No ☒Ambulance Required Yes () No ☒Nurse : RN or *L. Laguerre* LPN**SECTION 2 TO BE COMPLETED BY INMATE**

I authorize release of medical information to the Houston County Sheriff's Department.

George H. Rhodes Jr.

Date:

SECTION 3 TO BE COMPLETED BY PROVIDER
☐ Treated ☐ Further follow -up needed ☐ REFER for another Treatment or Test

DIAGNOSIS:	TREATMENT :

SIGNATURE OF PROVIDER

DATE

CLINIC DIRECTOR :
D. Speigner CRNPTelephones : (334) 712-0762 ext. 120 or 122
Sheriff's Office (334) 677- 4888

Southwest Alabama
MEDICAL
CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Page 1 of 2

Patient Identification

Printed Name: George, Rhodes Date of Birth: 4-6-65
 Address: 507 S. Ussery St.
Dothan, AL 36303
 Social Security #: 130-60-1743 Telephone: 334-794-5424

Information To Be Released - Covering the Periods of Health Care

From (date) 1/2004 to (date) 5/2005
 From (date) _____ to (date) _____

Please check type of information to be released:

- | | | |
|--|--|---|
| <input checked="" type="checkbox"/> Complete health record | <input type="checkbox"/> Face Sheet | <input type="checkbox"/> X-ray films / images |
| <input type="checkbox"/> Complete billing record | <input type="checkbox"/> History and physical exam | <input type="checkbox"/> X-ray reports |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Itemized bill | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Laboratory test results | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Emergency Dept. Reports | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Other, (specify) _____ | | |

Purpose of Request

- ☒ Treatment or consultation ☐ At the request of the patient ☐ Billing or claims payment
☐ Other, (specify) _____

Who and Where to Send / Release Information

Name: Houston County Jail
Nursing Department
 Address: 901 East Main Street
Dothan, AL 36301

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing records or psychotherapy notes contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.
 Circle One: Yes No

I understand if my medical or billing records or psychotherapy notes contain information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.
 Circle One: Yes No

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Medical Records Manager at Southeast Alabama Medical Center, P.O. Box 6987, Dothan, AL 36302. Unless revoked, this authorization will expire on the following date or event 5/2/06, or 180 days from date of signature, unless otherwise specified.



Continued...

**Southeast Alabama
MEDICAL
CENTER**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Page 2 of 2

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. SOUTHEAST ALABAMA MEDICAL CENTER, ITS AFFILIATES, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that my treatment or payment for services will not be denied if I do not sign this authorization unless specified on the other side of this form under Purpose of Request. I can inspect or receive a copy of the protected health information to be used or disclosed. I understand that there may be a charge for copies.

I authorize SOUTHEAST ALABAMA MEDICAL CENTER to use and disclose the protected health information specified on the other side of this form.

George Rhodes
Signature of Patient or Personal Representative

Date

5/2/05

Relationship if not patient: (Guardian/Executor of Estate/Personal Representative)

Day time phone number

Witness:

U. Hathaway

For Southeast Alabama Medical Center Use Only:

Patient's Medical Record # _____ Account # _____

Check Records Received by Patient:

- ☐ Complete health record
- ☐ Complete billing record
- ☐ Consultation reports
- ☐ Discharge summary
- ☐ Emergency Dept. Reports

- ☐ Face Sheet
- ☐ History and physical exam
- ☐ Itemized bill
- ☐ Laboratory test results
- ☐ Pathology Report

- ☐ X-ray films / Images
- ☐ X-ray reports

☐ OTHER _____

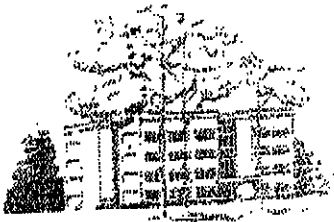
TOTAL PAGES SENT/GIVEN: _____

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specify _____

Verified by: _____

TELEPHONE FOR MEDICAL RECORDS: (334) 793-8864

SOUTHEAST ALABAMA MEDICAL CENTER
P. O. BOX 6987
MONTGOMERY, AL 36102-6987



DOTHAN SPECIALTY CLINIC

C-Pool

ADMINISTRATOR

Lois W. Sallas

CARDIOLOGY

R. Ronnie Harrell, M.D.
James A. Sawyer, III, M.D.
Chris E. Byard, M.D.
Michael E. Pinson, M.D.
S. Roland Brooks, M.D.
David D. Gayle, M.D.
Benjamin Craven, Jr., M.D.

PULMONARY & SLEEP DISORDERS

Allen Latimer, M.D.
Dale Prophet, M.D.
Alan W. Purvis, M.D.
Brian R. Sinclair, M.D.
Marvin W. Sexton, M.D.

NEUROLOGY & SLEEP DISORDERS

David A. Davis, M.D.

PSYCHIATRY & SLEEP DISORDERS

Ann B. McDowell, M.D.

PSYCHIATRY

C. Roby Hicks, M.D.

DERMATOLOGY

Robert B. Ash, M.D.
Craig D. Omohundro, M.D.
Laura M. Tamburin, M.D.
Tonia L. Ruddock, M.D.

RHEUMATOLOGY

Parks W. Pratt, III, M.D.

UROLOGY

Michael G. Simmons, M.D.
Mark A. Byard, M.D.

OPHTHALMOLOGY

Joseph H. Sugg, Jr. M.D.

FACSIMILE TRANSMITTAL COVER SHEET

TO: *Houston County Jail* DATE: *5-5-05*

FAX TO: *671-9482* PAGE *1* OF *4*

ATTENTION:

Mary

FROM: Barbara Bond

FAX#

Administration (334) 671-8907
Insurance (334) 712-0830
West Office (334) 712-4280
East Office (334) 712-2815

PHONE # (334) 793-9564

MESSAGE:

*request
not HIPAA compliant
fax send release form
to 712-2810*

The information contained in this transmission is privileged, confidential and is only intended for the use of the individual or entity named above. Failure to maintain the confidentiality or unauthorized re-disclosure of the information contained herein could subject you to penalties under state and federal guidelines. The recipient of this message is responsible for a secure location of the fax machine. If the recipient of this message is not the intended recipient, you are hereby notified that any copying, dissemination or distribution of this transmittal is strictly prohibited. If you have received this transmittal in error, please notify us immediately at 334-793-9564.

SUITE 102, 4300 WEST MAIN STREET, DOTHAN, ALABAMA 36305-1051 (334) 793-9564
SUITE 501, 1118 ROSS CLARK CIRCLE, DOTHAN, ALABAMA 36301-8041 (884) 793-8664

P.01

May 5 2005 14:38

Fax: 7122810

DSC MED REC

STATE OF ALABAMA
HOUSTON COUNTY

MEDICAL RELEASE AUTHORIZATION

KNOW ALL MEN BY THESE PRESENTS, THAT FOR AND IN CONSIDERATION OF HOUSTON COUNTY, ALABAMA, ASSUMING THE FINANCIAL RESPONSIBILITY OR LIABILITY FOR MY MEDICAL OR DOCTOR TREATMENT AND CARE, I DO HEREBY AUTHORIZE ANY SUCH MEDICAL DOCTOR OR HOSPITAL TO RELEASE ANY MEDICAL RECORDS OR INFORMATION TO ANY DULY APPOINTED OR AUTHORIZED REPRESENTATIVE OF HOUSTON COUNTY, ALABAMA.

HOWEVER, THIS MEDICAL RELEASE AUTHORIZATION IS SPECIFICALLY LIMITED TO PROPERLY AUTHORIZED HOUSTON COUNTY PERSONNEL; AND ANY SUCH MEDICAL DOCTOR OR HOSPITAL IS NOT AUTHORIZED TO RELEASE ANY SUCH MEDICAL INFORMATION OR TREATMENT INFORMATION TO ANY OTHER PERSON, COMPANY, OR CORPORATION, OTHER THAN BY MY FURTHER EXPRESSED AUTHORITY FROM ME AND MY ATTORNEY.

AFFIRM:

WITNESS

I, X George Rhodes, AN INMATE IN THE HOUSTON COUNTY JAIL, HAVE BEEN DULY INFORMED AND DO UNDERSTAND THE COST OF HOUSING AND MEDICAL CARE MAY BE ASSESSED AGAINST ME AS COST OF COURT, IF I AM CONVICTED OF A MISDEMEANOR IN THE DISTRICT COURT.

SIGNATURE

DATE:

WITNESS:

AUTHORIZATION FOR RELEASE

I George Rhodes

Patient's Name & Address

D. O. B. 4-6-65 do authorize Pinson to release(Physician)
to Houston County Jail - Clinic my protected health information.
(Name & address of person to receive information)Describe specifically the PHI you want released. All medical Records
Pertaining to Cardiology

This Authorization allows for the disclosure of protected health information for the particular purpose of: _____

Section A: I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, healthcare providers or clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Section B: Psychiatric Records

_____ This authorization is for psychiatric records. If this authorization is for psychiatric records, you must not use it as an authorization for any other type of protected health information use or disclosure.

Give date this authorization will expire if applicable: _____

I understand that I may revoke this authorization by giving written notice to the address listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before this revocation.

print → I, George Rhodes, have read and do understand the contents of this authorization. I confirm that this is consistent with my direction to you.

sign → George Rhodes
Signature of Patient

Date 5/5/05

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal representative name

Relationship to individual

Dothan Specialty Clinic

4300 West Main Street, Suite 102, Dothan, Alabama 36305 (334) 793-9564

You are entitled to a copy of this Authorization after you sign it. This authorization will be filed in the individual's medical record.

**HOUSTON COUNTY JAIL
INFIRMARY
901 EAST MAIN STREET
DOTHAN, ALABAMA 36301**

Phone (334) 671-9482
Fax (334) 671-9482

RECEIVED



FAX PAGE:

FACILITY: Cardiology Associates
PHYSICIAN: Dr. Pinson
DEPARTMENT: Medical Records

INMATE NAME:	D.O.B.	S.S. #
<u>George Rhodes</u>	<u>4-6-65</u>	<u>136-60-1743</u>

SIGNATURE Dwight J. Smith DATE 5-05-05
Please Send
Medical Records
Thanks
Dwight

OF PAGES 2

Any Problems with this FAX, Please call.

HOUSTON COUNTY JAIL
INFIRMARY
901 EAST MAIN STREET
DOTHAN, ALABAMA 36301

Phone (334)712-0762
Fax (334)671-9482



FAX PAGE :

FACILITY :

Same

PHYSICIAN :

DEPARTMENT :

Medical Records

INMATE NAME :	D.O.B.	S.S. #
<i>Rhodes, George</i>	<i>4-6-65</i>	<i>130-60-1743</i>

SIGNATURE

Wayne Smith

DATE

5-2-05

*faxed
5-02-05
1025 I.S.*

OF PAGES

3

Any Problems with this FAX, Please call .

HOUSTON COUNTY JAIL
INFIRMARY
901 EAST MAIN STREET
DOTHAN, ALABAMA 36301

Phone (334)712-0762

Fax (334)671-9482



FAX PAGE:

FACILITY: Cardiology Associates

PHYSICIAN: Dr. Pinson

DEPARTMENT: Medical Records

INMATE NAME:	D.O.B.	S.S. #
<u>George Rhodes</u>	<u>4-6-65</u>	<u>13660-1743</u>

SIGNATURE

[Handwritten Signature]

DATE

5-05-05

Please Send
Medical Records
Thanks
Ivery

OF PAGES

2

Any Problems with this FAX, Please call.

Correspondence

He
Copy

May 17, 2006

To: Commander McMullan

From: D. Speigner CRNP, Clinic Director

Regarding: Rhodes, George Henry #57322

This inmate has a serious medical condition. He has been seen by me, had a xray, had a MRI, been seen by Dr. Banner, and been evaluated by an Orthopedic Surgeon today. The physician has recommended a CAT scan guided biopsy. The diagnosis is tumor; rule out bone cancer.

It would be to everyone's best interest if this inmate was no longer housed in the Houston County Jail.

I am including a copy of his docket card for your information.

Thank You

5/30/06 Neither hosp. will accept this for to do this procedure.
per Dr. Speigner.

- Notified Cmdr. McMullan - will call Judge Jacks
" Lt. Rico
" Dr. Banner

Will attempt to refer

WEBB & ELEY, P.C.

JAMES W. WEBB
MICHAEL M. ELEY
* KENDRICK E. WEBB
CRAIG S. DILLARD
** DARYL L. MASTERS
FRANK E. BANKSTON, JR.
ROBBIE ALEXANDER HYDE

ATTORNEYS & COUNSELLORS AT LAW
7475 HALCYON POINTE DRIVE
POST OFFICE BOX 240909
MONTGOMERY, ALABAMA 36124

HOPE CURTIS
GARY L. WILLFORD, JR. †
C. RICHARD HILL, JR.
SCOTT W. GOSNELL *
ASHLEY HAWKINS FREEMAN
AMANDA KAY MORGAN

OF COUNSEL:
BART HARMON
KELLY GALLOPS DAVIDSON
WINTHROP E. JOHNSON

TELEPHONE (334) 262-1850
FACSIMILE (334) 262-1772
E-MAIL: contactfirm@webbeley.com

*ALSO ADMITTED IN DISTRICT OF COLUMBIA
**ALSO ADMITTED IN FLORIDA
†ALSO ADMITTED IN CALIFORNIA

April 21, 2006

DeeAnne Dennis
Claims Representative
Meadowbrook Insurance Group
2500 Fairlane Drive, Suite 100
Montgomery, AL 36116

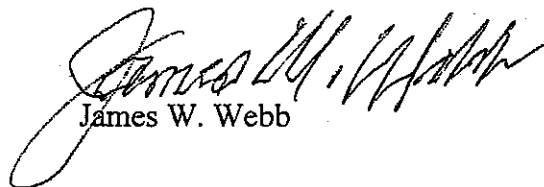
Re: George Henry Rhodes v. Houston County Commissioners, et al.
In the United States District Court for the Middle District of Alabama
Civil Action No. 1:04-CV-305-WHA
MIG File No. 15185DD
Webb & Eley No. 10010.850

Dear DeeAnne:

We have received a copy of Gary Sherrer's letter of April 19, 2006 to Hank Draughon, with which he enclosed a copy of the pro se complaint, order for special report, and his entry of appearance in the above-styled cause. You have advised that you are the adjuster assigned to handle this file.

This matter has been assigned to Gary Sherrer, the county attorney for Houston County, who will provide a defense for Houston County Commissioners, Sheriff Lamar Glover, Commander William B. McCarty and Nurse Practitioner Darla Speigner, and keep you fully advised of all proceedings. If I may be of any further assistance, please let me know.

Very truly yours,


James W. Webb

JWW/jp

cc: Hon. Lamar Glover, Sheriff
Commander William B. McCarty
Darla Speigner
Roy Roberts, Administrator
Mark Culver, Chairman
Gary C. Sherrer, Esq.

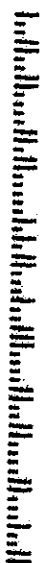
WEBB**& ELEY, P.C.**

ATTORNEYS & COUNSELLORS AT LAW
7475 HALCYON PONTE DRIVE
POST OFFICE BOX 240909
MONTGOMERY, ALABAMA 36124-0909



Darla Speigner
Houston County Sheriff's Officer
P. O. Box 6406
Dothan, AL 36302-6406

36302+6406



MONTGOMERY AL

25 APR 1 006 PM



H METER 5926 68

PROCEDURE: RIGHT FEMUR
HISTORY: Pain and swelling.
COMPARISON: @
TECHNIQUE: 2 views.

FINDINGS: There is coarse heterogeneous calcification in the soft tissues of the proximal thigh. This overlies the femur on several views but on 1 view appears to be separate from it. No definite fracture.

IMPRESSION:
INDETERMINATE CALCIFICATION IN SOFT TISSUE RIGHT UPPER THIGH. THIS MAY REPRESENT MYOSITIS OSSIFICANS, HOWEVER, MRI IS RECOMMENDED FOR FURTHER EVALUATION TO EXCLUDE MALIGNANCY.

Christopher Ahmed, MD

DD: 4/04/2006 17:11 nb
DT: 4/5/2006 08:53 123113

**FACSIMILE
COVER SHEET***Whatever you do, do it well.™*

www.samc.org

To: HOUSTON CO JAIL

Fax: 96719482

From: DTEW

Phone 334-793-8864

Pages: 3 (including banner)

Comment -

IMPORTANT NOTICE

This message is intended only for the use of the individual or entity to which it is addressed. It may contain information that is privileged, confidential and exempt from disclosure under law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the message to us, via the U.S. Postal Service, at the address below.

1108 ROSS CLARK CIRCLE, DOTHAN, AL 36301-3088
P.O. BOX 6987, DOTHAN, AL 36302-6987

**Southeast Alabama
MEDICAL
CENTER****Quality Services**

Behavioral Medicine Center
Cancer Center
Cardiology Center
Diabetes Treatment Center
Dothan Surgery Center
Emergency Center
Home Health Care
Home Medical Equipment
Industrial and
Occupational Health
Lithotripsy
Maternal & Infant Care
Neurodiagnostics
Open MRI
Outpatient Service Center
Pain Management Center
Radiology
Rehabilitation Services
Same Day Surgery
Sleep Disorders
Surgical Services
Women's Imaging Center

**COMMUNITY
OUTREACH**

Childbirth Education
Community Education
Community Health Education
Medical Call Center
Physician Information
& Referral
Senior Discovery Program
Support Groups
Adult Volunteers
Teenage Volunteer Program

**PRIMARY CARE
NETWORK**

Alabama
Enterprise Medical Clinic
Houston Medical Group

Florida
ChIPLEY Medical Group

OUTPATIENT REGISTRATION

**Southeast Alabama
MEDICAL
CENTER**

MR # 400545		ADMIT DATE 4/04/06		ADMIT TIME 15:55		ADMITTER OPHM		PT TYPE 1		PT # 2760518		
NAME RHODES JR, GEORGE HENRY						AGE 040Y		DOB 4/06/65		SEX M		
ADDRESS 507 S USSERY ST						REL JW		SRC 1		AD.CAT MD		
CITY DOTHAN						STATE AL		ZIP 36301		CLINICS		
PHONE 334 794-5424						PT SSN 136-60-4317		ATTENDING DOCTOR BANNER, SAM				
MAIDEN NAME						REFERRING DOCTOR UNASSIGNED						
ALLERGIES DRUG/FOOD/NLKA/NDM						DPA NO POWER		LW NO POWER		CITY HOUSTON, AL		
NEAREST RELATIVE				EMPLOYER SELF-EMPLOYED				EMERGENCY CONTACT				
ADDRESS				ADDRESS 507 S USSERY ST				ADDRESS				
CITY/STATE/ZIP				CITY/STATE/ZIP DOTHAN, AL 36301				CITY/STATE/ZIP				
PHONE		PT REL		PHONE 334 794-5424				PHONE		PT REL		
GUARANTOR # 6423197		SSN 136-60-4317		SELF-EMPLOYED				GUARANTOR EMPLOYER				
NAME RHODES JR, GEORGE HENRY						ADDRESS 1 507 S USSERY ST			ADDRESS 2			
ADDRESS 507 S USSERY ST						CITY/STATE/ZIP DOTHAN, AL 36301			DSCR			
PHONE 334 794-5424						PT REL PT		PHONE 334 794-5424			DAYS	
PATIENT STATES: XR/BACK PAIN												
ADMITTING DIAGNOSIS: XR/BACK PAIN												
INS#1: INMATES PRIVATE PAY				NAME RHODES JR, GEORGE H				GROUP #		POLICY # 136604317		
INS#2:												
INS#3:												
COMMENTS: REG/SCANNED/HEM												
PRINCIPAL & SECONDARY DIAGNOSIS										CODES		
										DATE DICTATED		
										D/S		
PROCEDURES & OPERATIONS/DATES										H&P		
										O.R.		
										CONS		

CONSULTATION WITH

PHYSICIAN SIGNATURE



Southeast Alabama Medical Center P.O. Box 6987 Dothan, AL 36302 334-793-8111

PRINTED BY: SAMC DATE 4/5/2006

#2049 Rev. 05/02

SOUTHEAST ALABAMA MEDICAL CENTER
PO Drawer 6987, Dothan, AL 36302
334-793-8111
RADIOLOGY SERVICES
XRAY REPORT

Patient Name: RHODES, GEORGE

XRAY/MR#: 000400545 Account #: 2760518 Room:XR- -
DOB: 04/06/1965 Age: 40 Pt Type: O
Order #: 00127605188183426 Accession #: 001000000130822
CDM: 3647366

Attending Physician: Sam Banner, MD

Ordering Physician: Sam Banner, MD

Referring Physician: UNASSIGNED

Exam Requested: FEMUR COMP RT

Exam Date: 04/04/2006

PROCEDURE: RIGHT FEMUR

HISTORY: Pain and swelling.

COMPARISON: @

TECHNIQUE: 2 views.

FINDINGS: There is coarse heterogeneous calcification in the soft tissues of the proximal thigh. This overlies the femur on several views but on 1 view appears to be separate from it. No definite fracture.

IMPRESSION:

INDETERMINATE CALCIFICATION IN SOFT TISSUE RIGHT UPPER THIGH. THIS MAY REPRESENT MYOSITIS OSSIFICANS. HOWEVER, MRI IS RECOMMENDED FOR FURTHER EVALUATION TO EXCLUDE MALIGNANCY.

Christopher Ahmed, MD

DD: 4/04/2006 17:11 nb

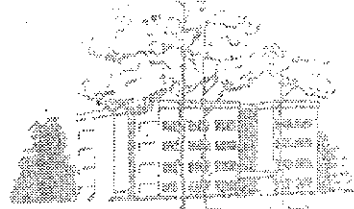
DT: 4/5/2006 08:53 123113

Name: RHODES, GEORGE

Christopher Ahmed, MD

{eop}

MR #: 000400545



DOTHAN SPECIALTY CLINIC

June 23, 2005

Medical Record Department of

Houston County Jail Infirmary
901 East Main Street
Dothan, AL 36301

ADMINISTRATOR

Lois W. Sallas

CARDIOLOGY

R. Ronnie Harrell, M.D.
James A. Sawyer, III, M.D.
Chris E. Byard, M.D.
Michael E. Pinson, M.D.
S. Roland Brooks, M.D.
David D. Gayle, M.D.
Benjamin Craven, Jr., M.D.

PULMONARY & SLEEP DISORDERS

Allen Latimer, M.D.
Dale Prophet, M.D.
Alan W. Purvis, M.D.
Brian R. Sinclair, M.D.
Marvin W. Sexton, M.D.

NEUROLOGY & SLEEP DISORDERS

David A. Davis, M.D.

PSYCHIATRY & SLEEP DISORDERS

Ann B. McDowell, M.D.

PSYCHIATRY

C. Roby Hicks, M.D.

DERMATOLOGY

Robert B. Ash, M.D.
Craig D. Omohundro, M.D.
Laura M. Tamburin, M.D.
Tonia L. Ruddock, M.D.

RHEUMATOLOGY

Parks W. Pratt, III, M.D.

UROLOGY

Michael G. Simmons, M.D.
Mark A. Byard, M.D.

OPHTHALMOLOGY

Joseph H. Sugg, Jr. M.D.

RE: George Rhodes

DOB: 4-6-65 SSN: _____

Additional information required:

() Patient's full name, () Maiden name/other name,
() Date of birth, () Dates of treatment and Type of
service, () Social Security Number, () Copy of Death
Certificate, () Name of Physician and/or Specialty from
which information is needed.

☒

We have no office records on this individual.

No authorization accompanied your request. Medical information is
confidential by law and can be released only on written consent of the patient.
If the patient is a minor and has reached the age 14 (fourteen), they must sign
the authorization.

We need a special authorization to release the requested information. (This
form is enclosed.)

A court order is required to obtain this information.

A subpoena must be validated thru our local court system.

A subpoena must be supplied by certified mail.

We have no records for the dates requested.

This information must be requested from the facility in which it was performed.

Faxed requests are not accepted. Requests must be received via mail.

Records prior to 2000 are not accessible.

Prepayment is required before records can be mailed. Please issue a check for
the amount of \$_____ to DOTHAN SPECIALTY CLINIC.
Tax ID #63-0837349.

Barbara Bond

Barbara Bond
Medical Record Release Coordinator
Dothan Specialty Clinic

5034917
cd

AUTHORIZATION FOR RELEASE

I George Rhodes

Patient's Name & Address

D. O. B. 4-6-65 do authorize Pinson to releaseto Houston County Jail - Clinic (Physician) my protected health information.
(Name & address of person to receive information)Describe specifically the PHI you want released. All medical Records
Pertaining to Cardiology

This Authorization allows for the disclosure of protected health information for the particular purpose of: _____

Section A: I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, healthcare providers or clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Section B: Psychiatric Records

_____ This authorization is for psychiatric records. If this authorization is for psychiatric records, you must not use it as an authorization for any other type of protected health information use or disclosure.

Give date this authorization will expire if applicable: _____

I understand that I may revoke this authorization by giving written notice to the address listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before this revocation.

print → George Rhodes have read and do understand the contents of this
sign → George Rhodes authorization. I confirm that this is consistent with my direction to you.

Signature of Patient

Date

5/5/05

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal representative name

Relationship to individual

Dothan Specialty Clinic

4300 West Main Street, Suite 102, Dothan, Alabama 36305 (334) 793-9364

You are entitled to a copy of this Authorization after you sign it. This authorization will be filed in the individual's medical record.

HK

EMERGENCY REGISTRATION

Southeast Alabama
MEDICAL
CENTER

MR # 400545	ADMIT DATE 1/11/05	ADMIT TIME 15:54	ADMITTER ESCR	PT TYPE 1	PT # 2541983
NAME RHODES, GEORGE			AGE 039Y	DOB 4/06/65	SEX M
ADDRESS 906 WILLIAMS AVE			REL JW	SRC 7	AD CAT ER
CITY DOTHAN	STATE AL	ZIP 36301	CLINICS	SPECIAL HDL P	MSV ER
PHONE 334 799-2563	PT SSN 136-60-4317	ATTENDING DOCTOR EMERGENCY MED DR			
MAIDEN NAME			REFERRING DOCTOR		
ALLERGIES DRUG/NKFA/NLKA/NDM			DPA NO POWER	LW NO POWER	CITY HOUSTON, AL
NEAREST RELATIVE RHODES GLENDA		EMPLOYER		EMERGENCY CONTACT RHODES GLENDA	
ADDRESS 906 WILLIAMS AVE		ADDRESS		ADDRESS 906 WILLIAMS AVE	
CITY/STATE/ZIP DOTHAN, AL 36301		CITY/STATE/ZIP		CITY/STATE/ZIP DOTHAN, AL 36301	
PHONE 334 799-2563	PT REL PA	PHONE		PHONE 334 799-2563	PT REL PA
GUARANTOR # 6423197	SSN 136-60-4317	GUARANTOR EMPLOYER			
NAME RHODES, GEORGE			ADDRESS 1		
ADDRESS 906 WILLIAMS AVE			ADDRESS 2		
CITY/STATE/ZIP DOTHAN, AL 36301			CITY/STATE/ZIP		DSCH
PHONE 334 799-2563	PT REL PT	PHONE		DAYS	
PATIENT STATES: BLUE					
ADMITTING DIAGNOSIS: BLUE					
INS#1:	NAME		GROUP #	POLICY #	
INS#2:					
INS#3:					
COMMENTS: QREG/PT SIGNED COT/SDC					
PRINCIPAL & SECONDARY DIAGNOSIS					CODES
					DATE DICTATED
					D/G
PROCEDURES & OPERATIONS/DATES					H&P
					O.R.
					Cons

CONSULTATION WITH

PHYSICIAN SIGNATURE



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Southeast Alabama

**MEDICAL
CENTER****EMERGENCY PHYSICIAN RECORD**
Dyspnea (COPD, CHF, and Other) (5)DATE: 11/11/05 TIME: 1618 ROOM: _____ EMS ArrivalHISTORIAN: patient spouse paramedics

HX / EXAM LIMITED BY: _____

V/S BP 100/68 HR 94 RR 20 Temp 98.2
Wt _____ O2Sat 97% Pain 2**HPI**chief complaint: shortness of breath (hx of: asthma / COPD / CHF)
weaknessstarted: yesterdaycontinues in ED
gone now better
intermittent
worse**severity:**mild moderate severe**exacerbated by:**exertion laying flat
coughing**associated symptoms:****PULMONARY**cough
• sputum
non-productive
blood-tinged sputum
frank hemoptysis**fever**• subjective / to _____ °F
sweating**CVS**chest discomfort
• left / right / central
upper / lower
• pain / discomfort / tightness
sharp / burning / pressure
worse with deep breaths
• constant / intermittent
duration: _____

leg / calf pain (R / L)

ankle swelling

OTHERlight-headed / dizzy
anxietytingling / numb
hands / feet / face
heart racing

Similar symptoms previously

Recently seen / treated by doctor

RHODES, GEORGE

DRUG/NKFA/NLKA/NDM

400545 2541983 4/06/65 039Y M

EMERGENCY MED DR 1/11/05

**ROS****ENT**sore throat
sinus drainage**CONST / GI**nausea
vomiting
abdominal pain
black / bloody stools
diarrhea
chills**NEURO / EYES**headache dizzy
fainting
visual disturbance**GU / ENDOCRINE**pain with urination
excessive urination**SKIN / LYMPH / MS**skin rash / swelling
joint painmuscle aches☐ all systems neg. except as marked**PAST HISTORY** negative past records ordered / reviewed

*PE Risk Factors

asthma
emphysema
heart disease
*CHF CAD angina MI
kidney failure / dialysis
*PE / DVT

*risk factors for PE / DVT

other problems

*hypertensiondiabetes insulin / oral / diet
high cholesterol*CVApneumonia
pneumothorax
bronchitis

acute chronic

Surgeries / Procedures none non-contributory

prior intubation

cardiac bypass

cardiac cath

angioplasty

cholecystectomy

appendectomy

hysterectomy

pacemaker

Medications none see nurses note

ASA NSAID acetaminophen

*BCP's home O2 @ _____ L

home nebulizer

Allergies NKDA

see nurses note

Iodine**SOCIAL HX**smoker drugs
alcohol (recent / heavy / occasional)**FAMILY HX** CAD

201

X EMT / Nurse MD / DO
HISTORY Nurse or EMT sign after recording history; physician initial
after reviewing with patient and confirming or revising all elements.

Southeast Alabama

**MEDICAL
CENTER**

RHODES, GEORGE

DRUG/NKFA/NLKA/NDM

400545 2541983 4/06/65 039Y M

EMERGENCY MED DR 1/11/05



PATIENT'S REFUSAL OF TREATMENT/EVALUATION

I wish to leave the Emergency Department of Southeast Alabama Medical Center without being fully evaluated by the Emergency Department staff. I am doing this without coercion or duress and of my own free will. I accept full responsibility for my decision to leave and hereby agree to release the emergency physicians, Southeast Alabama Medical Center of responsibility or liability that may result as a consequence of this action. I further acknowledge that I may have undiagnosed diseases, illnesses or injuries, which if untreated, could worsen or become life threatening, and I, nevertheless, decline treatment. I further acknowledge that the Emergency Department staff has offered to perform a medical screening examination, regardless of my ability to pay for such service, but that I have declined this evaluation/treatment. I acknowledge that I have been informed of the risk involved, the benefits or treatment, and hereby release the attending physician and the hospital from all responsibility for any ill effects, which may result from such discharge.

I have refused the following treatment/evaluation:

ER Treatment
MAJOR COMPLAINT: SOB/Weakness

I HAVE READ THIS FORM, AND I UNDERSTAND IT.

George Rhodes
Signature of Patient (or patient's agent)

1/11/05
Date

6:50 pm
Time

Belinda C. Herring
Witness

NONE / ER Regi
Relationship to patient

EMERGENCY REGISTRATION

Southeast Alabama
MEDICAL
CENTER

NR # 400545	ADMIT DATE 1/12/05	ADMIT TIME 14:29	ADMITTER ERJM	PT TYPE 1	PT # 2542516
NAME RHODES JR, GEORGE HENRY			AGE 039Y	DOB 4/06/65	SEX M
ADDRESS 507 S USSERY ST			REL JW	SRC 7	AD.CAT ER
CITY DOTHAN	STATE AL	ZIP 36301	CLINICS	SPECIAL HDL	MSV ER
PHONE 334 794-5424	PT SSN 136-60-4317	ATTENDING DOCTOR EMERGENCY MED DR			
MAIDEN NAME			REFERRING DOCTOR		
ALLERGIES NKDA/FOOD/NLKA/NDM			DFA NO POWER	LW NO POWER	CITY HOUSTON, AL
NEAREST RELATIVE RHODES GLENDA		EMPLOYER		EMERGENCY CONTACT RHODES, KEESHA	
ADDRESS 906 WILLIAMS AVE		ADDRESS		ADDRESS 507 S USSERY ST	
CITY/STATE/ZIP DOTHAN, AL 36301		CITY/STATE/ZIP		CITY/STATE/ZIP DOTHAN, AL 36301	
PHONE 334 699-2563	PT REL SO	PHONE		PHONE 334 794-5424	PT REL BR
GUARANTOR # 6423197	SSN 136-60-4317	GUARANTOR EMPLOYER			
NAME RHODES JR, GEORGE HENRY			ADDRESS 1		
ADDRESS 507 S USSERY ST			ADDRESS 2		
CITY/STATE/ZIP DOTHAN, AL 36301			CITY/STATE/ZIP		DSCH
PHONE 334 794-5424	PT REL PT	PHONE		DAYS	
PATIENT STATES: BLUE					
ADMITTING DIAGNOSIS: BLUE					
INS#1:	NAME		GROUP #	POLICY #	
INS#2:					
INS#3:					
COMMENTS: QREG/PT SIGNED/DENIES INJURY/JM					
PRINCIPAL & SECONDARY DIAGNOSIS					CODES
					DATE DICTATED
					D/S
PROCEDURES & OPERATIONS/DATES					H&P
					O.R.
					Cons

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Southeast Alabama

**MEDICAL
CENTER****EMERGENCY PHYSICIAN RECORD**

Chest Pain (5)

DATE: 1-12-05 TIME: 1446 ROOM: EMS Arrival

HISTORIAN: patient spouse paramedics

HX / EXAM LIMITED BY:

V/S BP 135/75 HR 70 RR 18 Temp 98.4
Wt 180 O2 Sat 98 Pain 0**HPI**

chief complaint: chest pain / discomfort

started: today

time course:still present better
gone now
lasted

resolved on arrival in ED

quality:pressure
tightness
indigestion
burning
dull
aching
sharp
stabbing
"pain"
"numbness"
"like prior MI"

radiation: none diagrammed above

associated symptoms:nausea shortness of breath
vomiting sweating**worsened by:**change in position
deep breaths / turning
exertion
nothing**relieved by:**sitting up
rest
antacids
nothing

NTG 1 2 3

patient's own supply
given by paramedics
relief: none / partial /
complete / transient
Oxygen NRB L**onset during:**sleep rest light activity
mod. / heavy exertion
emotional upset
cannot recall**severity:**maximum: (1-10) 7
mild moderate severe

when seen in ED: (1-10) 1

gone almost gone mild moderate severe
residual discomfort in arm (R/L)

Similar symptoms previously

Recently seen / treated by doctor

RHODES JR, GEORGE HENRY

NKDA/FOOD/NLKA/NDM

400545 2542516 4/06/65 039Y M

EMERGENCY MED DR

1/12/05

ROS

CHEST / CONST

fever
chills
cough
sputum
ankle swelling
calf / leg pain**NEURO**headache
blackouts**EYES / ENT**blurred vision
sore throat**GI / GU**abdominal pain
black / bloody stools
problems urinating**SKIN / LYMPH / MS**

skin rash / swelling

joint pain

all systems neg. except as marked

FEMALE REPRODUCTIVE

LNMP

vaginal discharge
abnormal bleeding**PAST HISTORY**

negative past records ordered / reviewed

*MI risk factors

high blood pressure

diabetes insulin / oral / diet

high cholesterol

heart disease

heart attack (MI)

angina / heart failure

DVT / PE / risk factors

GERD

latter problems

emphysema

collapsed lung

stroke

peptic ulcer

documented? yes no

gall stones

Surgeries / Procedures none non-contributory

cardiac bypass

cardiac cath

angioplasty

thrombolytics

pacemaker

consillectomy

cholecystectomy

appendectomy

hysterectomy

Medications none ASA NSAID

acetaminophen BCP's

see nurses note

Atenolol 25g

NTG

Allergies LNKDA

see nurses note

SOCIAL HX

alcohol (recent / heavy)

*smoker

4pk/day

FAMILY HX

UCAD (<55yo >55yo)

Father & Mother

201



HISTORICAL
HISTORY Nurse or EMT sign after recording history; physician initial
after reviewing with patient and confirming or revising all elements.

Southeast Alabama Medical Center

☒ Nursing Assessment Reviewed ☒ Vitals Reviewed

PHYSICAL EXAM

 Alert ☐ Anxious ☐ IV ☐
 Distress: LAD mild moderate severe

EENT

 eyes nml inspection scleral icterus / pale conjunctivae
☒ ENT nml inspection pharyngeal erythema
 pharynx nml abnml TM / hearing deficit

NECK

☒ nml inspection thyromegaly
 lymphadenopathy (R/L)

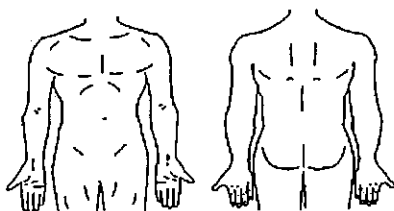
RESPIRATORY

☒ no resp. distress see diagram
☒ chest non-tender respiratory distress
☒ nml breath sounds manifests distinct pain on movement
 of (R/L) arm of trunk
 splinting / decr air mvmt
 rales
 rhonchi
 wheezing

CVS

☒ regular rate, rhythm irregularly irregular rhythm
☒ no murmur extrasystoles (occasional / frequent)
☒ no gallop tachycardia / bradycardia
☒ no friction rub PMI displaced laterally
 JVD present
 murmur grade /6 sys / dias
 cresc / cresc-decresc / decresc
 gallop (S3 / S4)
 friction rub

 decreased pulse(s)
 R carotid fem dors ped
 L carotid fem dors ped

 T = tenderness
 Grav = guarding
 R = rebound
 m = mild
 mod = moderate
 sv = severe
 (e.g., Tsv = severe
 tenderness)


ABDOMEN

☒ non-tender tenderness
☒ no organomegaly guarding
 rebound
 abnml bowel sounds
 hepatomegaly / splenomegaly / mass

RECTAL

 non-tender black / bloody / heme pos. stool
 heme neg stool tenderness

SKIN

☒ color nml, no rash cyanosis / diaphoresis / pallor
☒ warm, dry skin rash

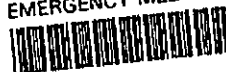
EXTREMITIES

☒ non-tender pedal edema
☒ normal ROM calf tenderness
☒ no pedal edema clubbing
☒ no calf tenderness

NEURO / PSYCH

☒ oriented x3 disoriented to person / place / time
☒ mood / affect nml depressed affect
☒ CN's nml as tested facial droop / EOM palsy / anisocoria
☒ no motor / sensory deficit weakness / sensory loss

RHODES JR, GEORGE HENRY

 NKDA/FOOD/NLKA/NDM
 400545 2542516 4/06/65 039Y M
 EMERGENCY MED DR 1/12/05


LABS, EKG, XRAYS and PROGRESS

CBC	Chemistries	CK	UA
normal except	normal except		normal except
WBC 4.3	Creat	CKMB	WBC
Hgb	Na	Troponin	RBC's
Hct	K		bacteria
Platelets	Cl		dip
segs	CO2		
bands	BUN	PT	
lymphs	Gluc	PTT	
monos	Anion Gap	INR	

 EKG MONITOR STRIP NSR Rate

 EKG ☒ NML ☐ Interp. by me ☒ Reviewed by me Rate
 NSR nml intervals nml axis nml QRS nml ST/T

 not / changed from:
 Repeat EKG unchanged /

 CXR ☐ Interp. by me ☒ Reviewed by me ☐ Discd w/ radiologist
 nml / NAD no infiltrates nml heart size nml mediastinum

 not / changed from:
 Pulse Ox % on RA / L / % at (time)

Time unchanged improved re-examined

 Offered admission - H. did not
 want admission - back pain
 Stress Test - H. did not
 referred chest pain walking

 Discussed with Dr. CRIT CARE- 80-74 min
 will see patient in: office / ED / hospital 75-104 min min
 Counselor patient / family regarding: Admit orders written
 lab results diagnosis need for follow-up Additional history from:
 Rx given family caretaker paramedics

CLINICAL IMPRESSION:

Chest Pain - acute precordial	Acute MI
Chest Wall Pain - acute	Unstable Angina
Dyspnea - acute	Pericarditis - acute
Costochondritis - acute	Acute Aortic Dissection
Myofascial Strain - acute	Pulmonary Embolism
Viral Syndrome - acute	Acute Pulmonary Edema / CHF
Bronchitis - acute	Atrial Fibrillation - rapid vent. response
Viral Pleuritis (Pleurisy)	controlled uncontrolled new-onset chronic
Abnormal EKG	Pneumonia
GERD	Pneumothorax

 DISPOSITION- ☒ home ☐ admitted ☐ transferred
 CONDITION- ☐ unchanged ☐ improved ☒ stable

 Certified Emergency ☒ Yes ☐ No ☐ Template Complete MD / DO

Southeast Alabama
**MEDICAL
CENTER**

Emergency Department
NURSING RECORD

RHODES JR. GEORGE HENRY

NKDA/FOOD/NLKA/NDM

400546 2642516 4/06/65 039Y M

EMERGENCY MED DR

1/12/05

bottom edge of patient label

*Items must be completed

Date: _____ Time: _____

*Triage VS: B/P _____ HR _____ Resp _____ Temp _____ O ₂ Sat _____		Allergies: <u>NKDA</u>																																		
Pain _____ WT _____ Private DR.: <u>2</u>																																				
Pre-Hosp	Arrival: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheel chair <input type="checkbox"/> Stretcher	<table border="1"> <thead> <tr> <th>Drug</th> <th>Dose</th> <th>Schedule</th> </tr> </thead> <tbody> <tr> <td><u>Demerol</u></td> <td></td> <td></td> </tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> </tbody> </table>		Drug	Dose	Schedule	<u>Demerol</u>																													
	Drug			Dose	Schedule																															
<u>Demerol</u>																																				
Transport Service: _____	Pre-Tx: <input type="checkbox"/> Ambu / BVM <input type="checkbox"/> IV Fid x _____ <input type="checkbox"/> Oral Airway																																			
<input type="checkbox"/> C-Collar/CID <input type="checkbox"/> Splint <input type="checkbox"/> O ₂ @ _____	<input type="checkbox"/> Back Board <input type="checkbox"/> ET / Size _____ <input type="checkbox"/> Dressing																																			
CV	*Skin Condition: <input type="checkbox"/> Cool <input type="checkbox"/> Edema: <input type="checkbox"/> Legs <input type="checkbox"/> Ankles <input type="checkbox"/> Feet <input type="checkbox"/> Warm <input type="checkbox"/> Clammy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hot <input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Decubitus <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Size _____ <input type="checkbox"/> Rash <input type="checkbox"/> Other _____																																			
	*Skin Color: <input type="checkbox"/> Pale <input type="checkbox"/> Hemorrhage: <input type="checkbox"/> None <input type="checkbox"/> Gross <input type="checkbox"/> Dusky <input type="checkbox"/> Cyanotic <input type="checkbox"/> Est. loss _____ cc <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced CRT: <input type="checkbox"/> < 2 sec. <input type="checkbox"/> > 2 sec. Dressings: _____																																			
	*Resp: <input type="checkbox"/> Unlabored <input type="checkbox"/> Labored <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Dyspnea <input type="checkbox"/> Other: _____ *BS: <input checked="" type="checkbox"/> Clear <input type="checkbox"/> Wheezes <input type="checkbox"/> Diminished <input type="checkbox"/> Absent <input type="checkbox"/> Adventitious																																			
	*LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Unresponsive <input type="checkbox"/> Disoriented <input type="checkbox"/> Oriented *Response to Stimuli: <input type="checkbox"/> Verbal <input type="checkbox"/> Tactile <input type="checkbox"/> Pain <input type="checkbox"/> Non-responsive *Speech: <input checked="" type="checkbox"/> Clear <input type="checkbox"/> Slurred Motor: L <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> VA <input type="checkbox"/> R Eye _____ Intact: <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> L Eye _____ Sensory: <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> Both Eyes _____ Reaction: <input type="checkbox"/> PEARLA <input type="checkbox"/> Pupil Size: _____ <input type="checkbox"/> Dilated <input type="checkbox"/> Constricted <input type="checkbox"/> L Eye _____ <input type="checkbox"/> Sluggish <input type="checkbox"/> Unresponsive Developmentally Appropriate for age: <input type="checkbox"/> Yes <input type="checkbox"/> No																																			
GI	Bowel Sounds: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Vomiting <input type="checkbox"/> Other: _____ Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Distended <input type="checkbox"/> Tender RUQ / RLQ / LUQ / LLQ / Epigastric / Periumbilical / Suprapubic																																			
	Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input checked="" type="checkbox"/> Read <input type="checkbox"/> Write Learning Preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Written <input type="checkbox"/> Demo (check all that apply.) Religious or cultural beliefs that need to be considered in Healthcare? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: _____ Do you need assistance with: <input type="checkbox"/> Mobility <input type="checkbox"/> Hygiene <input type="checkbox"/> Dressing <input type="checkbox"/> Eating <input type="checkbox"/> Toileting If assistance is required with any of the above, who did you receive it from (name) _____ If assistance is needed at discharge, who might help (name of person or persons) _____ Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ Have you had any weight gain or loss of 10 pounds or more within the last two weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been physical injured by anyone? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Explain: _____ Are your basic needs being met at home? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Explain: _____																																			
MS	ORTHO Extremity R/L _____ Motor Intact <input type="checkbox"/> Yes <input type="checkbox"/> No Sensory Intact <input type="checkbox"/> Yes <input type="checkbox"/> No Circulation Intact <input type="checkbox"/> Yes <input type="checkbox"/> No Deformity <input type="checkbox"/> Yes <input type="checkbox"/> No	LACERATION Site _____ Size _____ cm Bleeding Controlled <input type="checkbox"/> Yes <input type="checkbox"/> No Motor Intact <input type="checkbox"/> Yes <input type="checkbox"/> No Sensory Intact <input type="checkbox"/> Yes <input type="checkbox"/> No Circulation Intact <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature: <u>Amica Poole RN</u> IHN: Paged: _____ <input type="checkbox"/> Drug Screen <input type="checkbox"/> Yes <input type="checkbox"/> No IHN Signature: _____ <input type="checkbox"/> Police <input type="checkbox"/> Animal Control																																	
	Notifications DR, paged _____ ED DR. to see _____ DR. notified _____ ED DR. to see and call _____ Pvt DR. to see _____																																			

Safety:

☒ Armband
☒ Side Rails


NKDA/FOOD/NLKA/NDM

400545 2542516 4/06/65 039Y M

EMERGENCY MED DR

1/12/05

Southeast Alabama

MEDICAL CENTER

**EMERGENCY DEPARTMENT
NURSING RECORD**

bottom edge of patient label

[illegible]

Southeast Alabama
**MEDICAL
CENTER**

**EMERGENCY DEPARTMENT
NURSING RECORD**

RHODES JR, GEORGE HENRY
NKDA/FOOD/NLKA/NDM
400545 2542516 4/06/05 039Y M
EMERGENCY MED DR 1/12/05



bottom edge of patient label

DATE: 1-12-05

TIME	NURSING NOTES	
1440	Admitted ED % CP mid sternal, pt states "heart fluttering", A Fib on ECG skin temp. Debra Blair Charge nurse informed, EKG requested, post monitor requested	WBP/solent
1450	informed Debra Blair CP again about need for EKG + Indica Monitor, NO response	WBP/solent
1505	Report to Torula RN	WBP/solent
1535	Denies pain. Monitor shows NSR	20
1600	Recollected 1cc blood sent to lab	20
1603	Dr. Baker @ BS for eval	20
1633	awaiting orders. No distress	20
1700	CC UA obtained + sent to lab	20
1730	Inst. on delay	20
1800	Denies pain. No acute distress	20
1830	Dr. Baker @ BS	20
1911	Discharged home. No distress. NSR.	20

Discharge / Transfer	Report to: _____ Room #: _____	Signatures	SIGNATURES	INITIALS
	Destination: _____ (Transfer Only) <input type="checkbox"/> Monitor		<i>Debra Blair RN</i>	<i>MB</i>
	ID Band R / L Arm / Leg (for Transfer/Admit only)		<i>Torula Day RN</i>	<i>TD</i>
	Accompanied by: <input type="checkbox"/> Transport <input type="checkbox"/> Significant Other <input type="checkbox"/> Police <input type="checkbox"/> Nurse			
	Discharge via: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Stretcher <input type="checkbox"/> Wheelchair			
	Referrals: _____			
	Prescriptions: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Care Partner			
	Discharge Instructions <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Care Partner			
	Understanding Verbalized: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Care Partner			
	IV Cath Removed with Catheter Intact <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			
DC VS: BP <u>124/72</u> Resp <u>18</u> Temp _____ Time of DC <u>1911</u>				

**Southeast Alabama
MEDICAL
CENTER**
**Emergency Department
PHYSICIAN ORDERS**

 RHODES JR, GEORGE HENRY
 NKDA/FOOD/NLKA/NDM
 400545 2542516 4/06/65 039Y M
 EMERGENCY MED DR
 1/12/05

bottom edge of patient label

Circle tests, circle or write rationales.

The listed rationales are provided only for convenience; they are not an exclusive list.

Select or write any rationale that is appropriate.

TEST	RATIONALE		
• UA CC • UA Cath	Dysuria / Hematuria / Frequency / F.U.O. / Abd Pain / Trauma / Diabetes / Pregnancy / Other:		
• UPT • HCG Quant	Amenorrhea / Pg & Vag Bleeding / Abd Pain / Other:		
• Wet Prep	Vaginitis / Pelvic Pain / Abd Pain / Other:		
• CBC • WBC w/ DIFF	SOB / F.U.O. / Trauma-explain / Bleeding-explain / Abd Pain / H-Risk Med / Weakness / Anemia / Pallor / High Risk Med / Other:		
• Islat - • H&H • BMP	Bleeding-explain / Trauma-explain / Weakness / Anemia / Other:		
• Glu • CBG	HTN / CVD / Renal Failure / H-Risk Med / Other: <i>chest pain</i>		
• CMP	Dizziness / Near Syncope/Syncope / Vol Depletion / Other:		
• CK Total • CK-MB • Troponin • BNP	HTN / Renal Failure / H-Risk Med / Coma / Seizures / Dizziness / Fatigue / Edema / Other:		
• Amylase	Chest Pain / CHF / HTN / Dyspnea / Chest Trauma / Dysrhythmia / Other:		
• MBA	Abd Pain / Abd Trauma / Other:		
• PT • PTT	Altered Mental Status / OD / Other:		
• T&S • T&M x units	Anti-Coag / Bleeding-explain / Trauma-explain / Angina / PVD / Arteriosclerosis / Ascites / Other: (SMC) / Mitral Valve Disease / Hepatitis / Hematuria / Dysrhythmias / Cirrhosis /		
• Blood Culture	Bleeding-explain / Anemia / Other:		
• ABG	F.U.O. / Sepsis / Other:		
• EKG	Dyspnea / Inhalation Inj / Chest Pain / Other:		
• IVP	Chest Pain / SOB / HTN / Dysrhythmia / OD / Syncope / CAD / Other:		
• OB US	Abd Pain / Abd Trauma / Hematuria / Other:		
• ABD US	Pg & Vag Bleed / Pelvic Pain / Other:		
• CT Head	Back Pain / Flank Pain / Abd Pain / Ascites / Cirrhosis / Liver Disorder / Other:		
• CT Face	Headache / Stroke/TIA / Sz / Altered MS / Syncope / Head Trauma / Other:		
• CT Chest (thorax)	Facial Trauma / Other:		
• CT Abd/Pelvis	Chest Pain / Chest Trauma / Other:		
• CT of:	Abd Pain / Malignancies / Abdominal Swelling / Rigidity / Tenderness / Other:		
• MRI of:	Rationale:		
• CXR 2V P	Rationale:		
• Upright ABD • KUB • Acute ABD Series	Chest Pain / Cough / F.U.O. / Trauma to trunk-explain / COPD / Asthma / Any abnormal respiration / Other: <i>cut patient Cardiology 6/21/06</i>		
• XR Skull	Abd Pain / GI Bleed / Abd Trauma / Other:		
• XR Orbic: R L	• XR Pelvis	• XR Shoulder: R L	Trauma / Pain / FB / Other:
• XR Facial	• XR Hip: R L	• XR Humerus: R L	Trauma / Pain / FB / Other:
• XR Zygoma	• XR Femur: R L	• XR Elbow: R L	Trauma / Pain / FB / Other:
• XR C-Spine	• XR Knee: R L	• XR Forearm: R L	Trauma / Pain / FB / Other:
• XR T-Spine	• XR Tib/Fib: R L	• XR Wrist: R L	Trauma / Pain / FB / Other:
• XR LS Spine	• XR Ankle: R L	• XR Hand: R L	Trauma / Pain / FB / Other:
	• XR Foot: R L	• XR Other: R L	Trauma / Pain / FB / Other:

ORDERS:
☐ Old Record ☐ Cardiac Monitor ☐ FHTs ☐ Tilt Test ☐ Sz Precaution ☐ Suicide Precaution ☐ VA ☐ Off Unit w/o Nurse/Monitor
☐ Social Service Consult ☐ Poison Control Consult ☐ Wound Care ☐ Wound Irrigation ☐ Suture Setup ☐ I&D Setup ☐ Foley
☐ O2 Protocol ☐ O2: ☐ Peak Flow ☐ May Remove C-Collar ☐ Aerosol

 BIV: *we*
OTHER ORDERS:
UETS
NTP
to chest wound
complete vital signs plz
Physician Signature: *MD*

Date: _____

Time: _____

Run: 01/13/05 01:36

Page#: I9U-001
Room#: ER

RHODES, GEORGE HENRY JR
Ward: Emergency Room
Pt#: 2542516 (U: 400545)
Age: 39Y Sex: M
Physician: BAKER, D VAN

HEMATOLOGY

COMPLETE BLOOD COUNT

Collected:	01/12/05		
	15:40		
WBC	4.3 L	Normals	Units
		(4.5-10.0)	X (10)3
RBC	4.98	(4.40-5.90)	X (10)6
HGB	14.8	(13.0-18.0)	g/dL
HCT	44.0	(39.8-52.2)	%
MCV	88.4	(80.0-97.0)	fL
MCH	29.7	(26.0-34.0)	pg
MCHC	33.6	(31.0-37.0)	g/dL
RDW	15.1 H	(11.5-14.5)	%
PLT	179	(150-450)	X (10)3
MPV	8.9	(7.4-10.4)	fL
%Neutrophils	42.5	(40.0-70.0)	%
%Lymphocytes	34.9	(20.0-40.0)	%
%Monocytes	12.3	(5.0-13.0)	%
%Eosinophils	9.4 H	(4.0-8.0)	%
%Basophils	0.9	(0-1.0)	%
Neutrophil Abs.#	1.8	(1.8-7.3)	x10-3/ul
Lymphocyte Abs #	1.5	(1.1-4.4)	x10-3/ul
Monocytes Abs #	0.5	(0.2-0.8)	x10-3/ul
Eosinophil Abs #	0.4	(0.05-0.4)	x10-3/ul
Basophils Abs #	0.0	(0-0.1)	x10-3/ul

COAGULATION

ROUTINE COAGULATION

Collected:	01/12/05		
	15:40		
Protime	13.6	Normals	Units
		(11.1-14.1)	sec.
INR	1.09		
PTT	28.1	(21.8-30.3)	sec.

Protime: Therapeutic range = 24.1 - 40.6 sec

INR: Therapeutic range = 2 - 3.5

APTT: Therapeutic range = 53.7 - 100.6 sec.

RHODES, GEORGE HENRY JR 2542516 ER

Page#: I9U-001

***** PERMANENT PATIENT RECORD: DO NOT DISCARD *****

Run: 01/13/05 09:36
 Case 1:06-cv-00305-WHA-SRW
 RHODES, GEORGE HENRY JR

2542516

Document 14-7

Filed 06/23/2006

Page 49 of 57

URINALYSIS

URINE TOXICOLOGY

Collected:	01/12/05 17:13		Normals	Units
DS-PCP	Absent		(Absent)	
DS-Benzodiazepin	Absent		(Absent)	
DS-Cocaine	Absent		(Absent)	
DS-Amphetamine	Absent		(Absent)	
DS-THC	Absent		(Absent)	
DS-Opiates	Absent		(Absent)	
DS-Barbiturate	Absent		(Absent)	
DS-Tricyclics	Absent		(Absent)	

Note: "Present" indicates a preliminary test result. A more specific alternative chemical method must be used in order to obtain a confirmed analytical result. Specimen will be held 7 days pending medical order for confirmation.

CHEMISTRY

CHEMISTRY PROFILES

Collected:	01/12/05 15:40		Normals	Units
Protein, Total	6.3		(6.0-8.0)	g/dL
Albumin	3.5		(3.2-5.0)	g/dL
Calcium	9.2		(8.5-10.5)	mg/dL
Bilirubin, Total	0.7		(0.2-1.2)	mg/dL
Phosphatase, Alk	64		(42-121)	U/L
AST, SGOT	23		(10-42)	U/L
ALT, SGPT	17		(10-60)	U/L
Creatinine	1.1		(0.5-1.2)	mg/dL
BUN	14		(6-22)	mg/dL
Sodium	141		(135-145)	mEq/L
Potassium	4.0		(3.6-5.0)	mEq/L
Chloride	104		(100-110)	mEq/L
CO2	30		(25-31)	mEq/L
Glucose	93		(70-115)	mg/dL
Bun/Creat Ratio	12.7		(6.0-20.0)	
Anion Gap	7.0		(6.0-20.0)	
Calc. Osmolality	281		(273-304)	
A/G Ratio	1.3		(1.1-1.8)	
Globulin	2.8		(2.3-3.5)	

CARDIAC INJURY PROFILE

Collected:	01/12/05 15:40		Normals	Units
CK, total	120		(22-269)	U/L
CK-MB	1.7		(0.6-6.3)	ng/mL

Continued on next page

RHODES, GEORGE HENRY JR

2542516

ER

Page#: I9U-002

***** PERMANENT PATIENT RECORD: DO NOT DISCARD *****

CARDIAC INJURY PROFILE

Collected: 01/12/05
15:40

Normals Units

Continued from previous page

CK Index N/A

Troponin-I <0.01

(0-0.04) ng/mL

BNP 6

(0-100) pg/mL

CARDIAC TROPONIN I INTERPRETATION:

Test Manufacturer Recommendation:

Normal: Less than 0.04 ng/ml

Intermediate: 0.05 - 0.5 ng/ml

AMI: Greater than 0.5 ng/ml

American College of Cardiology Standard:

Abnormal Troponin I level exceeds 99% of reference
healthy control group. SAMC study defines this level
as greater than 0.04 ng/ml

BRAIN NATRIURETIC PEPTIDE Reference Range

New York Heart Association CHF Classification

Normal 0 - 50 pg/ml

Class I 51 - 100 pg/ml

Class II 101 - 200 pg/ml

Class III 201 - 600 pg/ml

Class IV Over 601 pg/ml

Non-CHF Pop./Neurohormonal Sys. Activation Cut-Off: >75 pg/ml

END OF REPORT

RHODES, GEORGE HENRY JR

2542516

ER

Page#: I9U-003

***** PERMANENT PATIENT RECORD: DO NOT DISCARD *****

M. DOWNING, M.D. - S.N. TURNER, M.D. - H. HOLLOWAY, M.D.
W. BECKETT, JR., M.D. - R. SYKLAWER, M.D.
DAVID A. BRINK, M.D. - C. AHMED, M.D. - ERIC LUND, M.D.
JULIA ALEXANDER, M.D. - STEPHEN FERNANDEZ, M.D.

Radiologists

E D X - R A Y R E P O R T

DATE/TIME TRANSCRIBED: 01/13/2005 1035

NAME: RHODES, GEORGE

ROOM#: ER

DOB: 04/06/1965

AGE: 39Y

XRAY#/MR#: 400545

ACCT#: 2542516

ATTENDING PHYSICIAN: VAN BAKER, D.O.

ORD#: 5870984

CPT CODE: 71010

CLINICAL INFORMATION:

EXAM REQUESTED: CHEST PORTABLE

EXAM DATE: 01/12/2005

PT TYPE: O

PROCEDURE: CHEST, 1625

HISTORY: Chest pain

COMPARISON: None

TECHNIQUE: AP portable

FINDINGS:

Lungs are clear. Heart and bones unremarkable.

IMPRESSION: UNREMARKABLE AP CHEST.

HUGH HOLLOWAY, MD

1

2

\: ko

/: 671

DD: 01/12/2005

DT: 01/13/2005

ID: 001470199

TD: 2234

FC:

cc: CHARGE COPY (99040)

>

{eop} RHODES, GEORGE

400545

Authenticated by HUGH HOLLOWAY, MD

On 1/18/05 5:15:08 PM

RHODES, GEORGE
39 yrs Male
12 JAN 2005 15:20:10

400545

PR 146 (NSR) . Normal sinus rhythm, rate 70 - NORMAL ECG -
QRS 77
QT 348
QTc 375

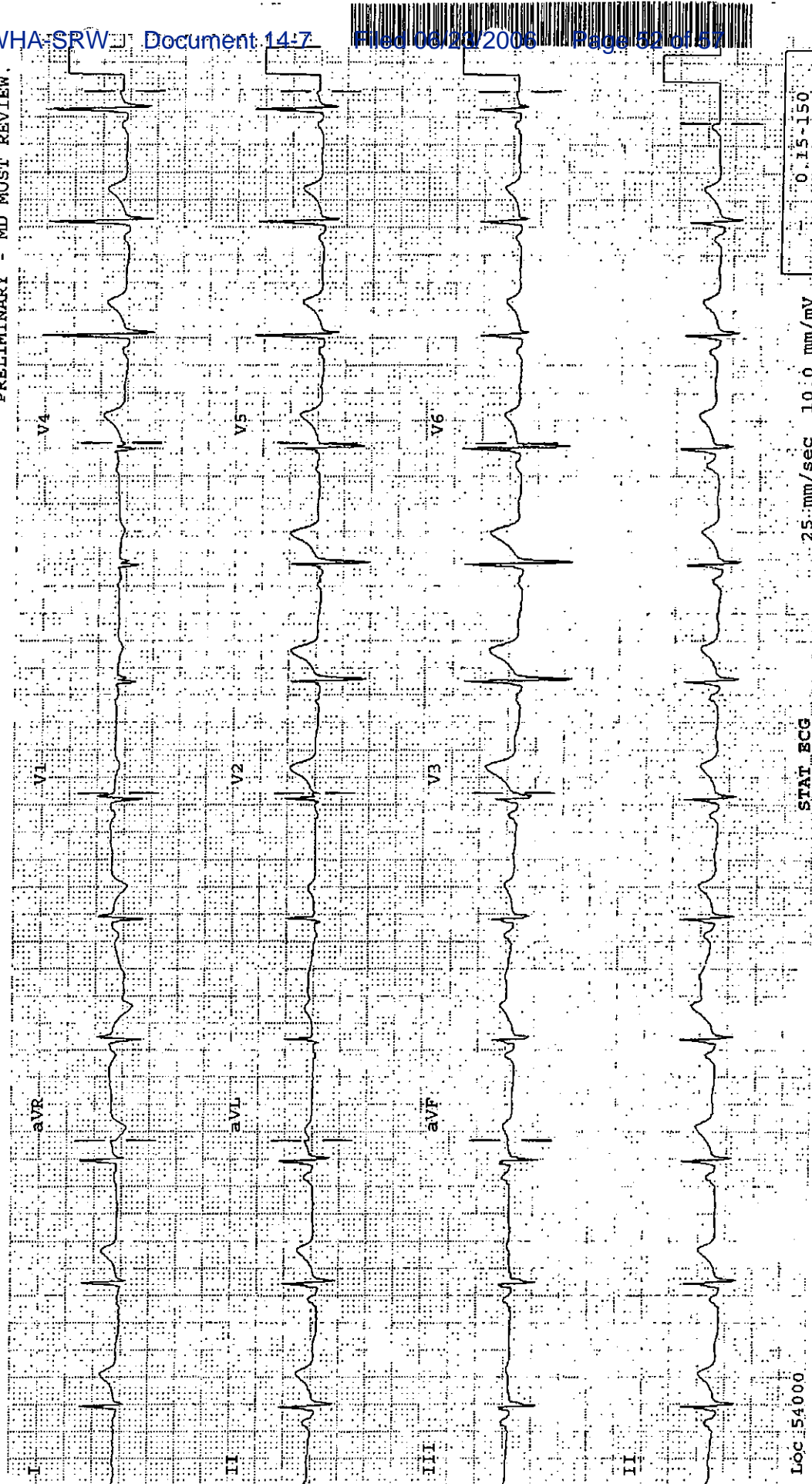
--AXES--
P 75
QRS 11
T 36

Southeast Alabama Medical Center -

Requested by
ED
Tech 9701
Room ED 2
C-HP708

[Signature]

PRELIMINARY - MD MUST REVIEW.



Loc 54000

STAT ECG

25 mm/sec 10.0 mm/mV

0.15-150

400545

01/12/2005 15:20:10
39 years Male

RHODES, GEORGE

southeast alabama medical center

Dx:

Dept: BID
Room: BID 2
Oper: 9701

Rate 70 Normal sinus rhythm, rate 70.....Normal P axis, PR, rate & rhythm

2542516

PR 146
QRSD 77
QT 348
QTc 375

RHODES JR, GEORGE HENRY

--AXIS--
P 75
QRS 11
T 36

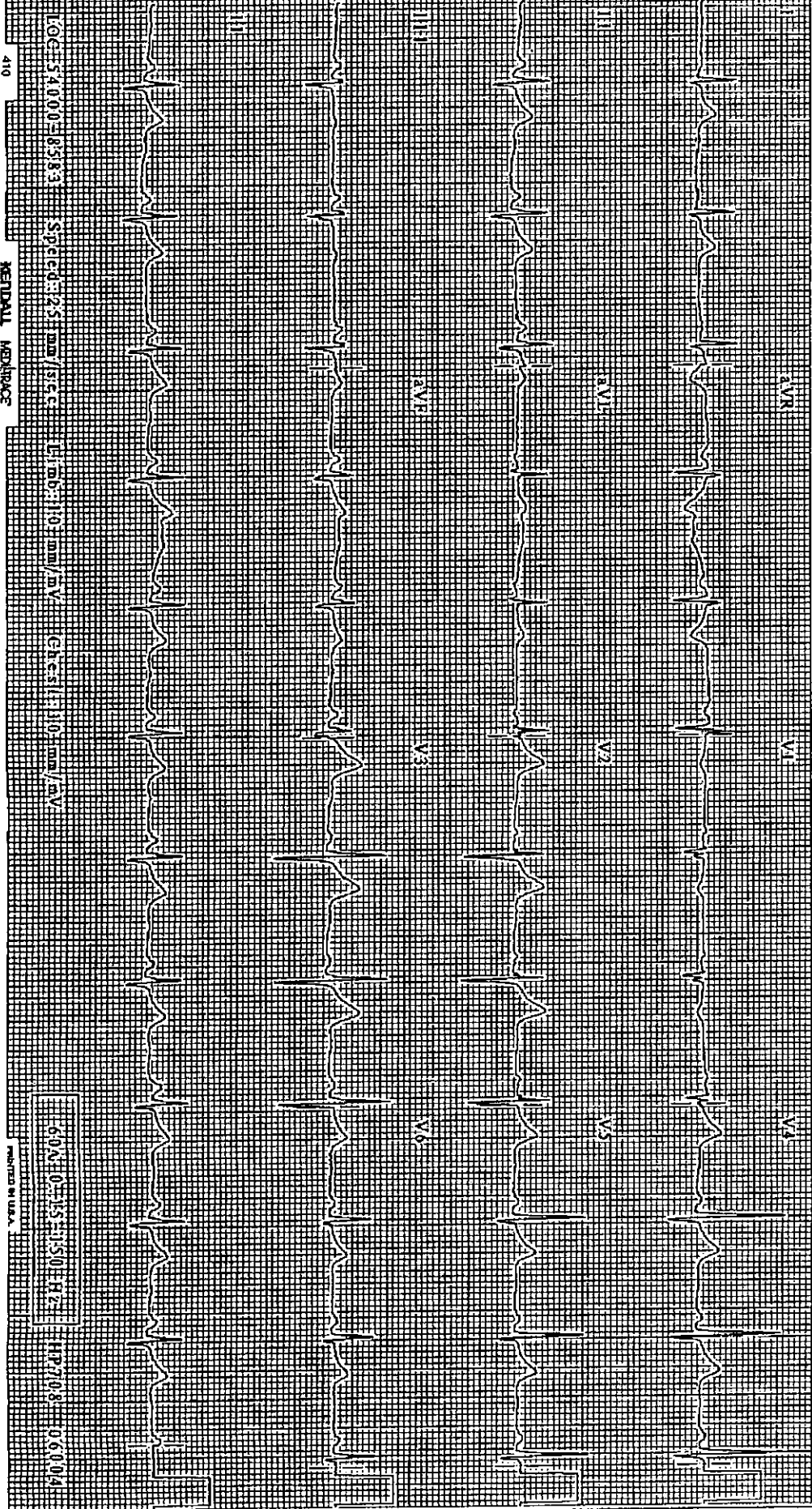
NKDA/FOOD/NLKA/NDM
400545 2542516 4/06/65 039Y M
EMERGENCY MED DR 1/12/05



- NORMAL ECG -

Requested by:
ED

PRELIMINARY-MD MUST REVIEW



OUTPATIENT REGISTRATION

Southeast Alabama
MEDICAL
CENTER

MR # 400545	ADMIT DATE 1/20/05	ADMIT TIME 9:05	ADMITTER OPEL	PT TYPE 1	PT # 2542897
NAME RHODES JR, GEORGE HENRY			AGE 039Y	DOB 4/06/65	SEX M
ADDRESS 507 S USSERY ST			REL JW	SRC 1	AD CAT MD
CITY DOTHAN	STATE AL	ZIP 36301	CLINICS	FC P	SPECIAL HDL MSV PLS
PHONE 334 794-5424	PT SSN 136-60-4317	ATTENDING DOCTOR BAKER, L, DWIGHT			
MAIDEN NAME		REFERRING DOCTOR PINSON, MICHAEL, E			
ALLERGIES NKDA/FOOD/NLKA/NDM			DPA NO POWER	LW NO POWER	CITY HOUSTON, AL
NEAREST RELATIVE RHODES, GLENDA	EMPLOYER SELF-EMPLOYED	EMERGENCY CONTACT RHODES, KEESHA			
ADDRESS 906 WILLIAMS AVE	ADDRESS 507 S USSERY ST	ADDRESS 507 S USSERY ST			
CITY/STATE/ZIP DOTHAN, AL 36301	CITY/STATE/ZIP DOTHAN, AL 36301	CITY/STATE/ZIP DOTHAN, AL 36301			
PHONE 334 699-2563	PT REL SO	PHONE 334 794-5424	PHONE 334 794-5424	PT REL BR	
GUARANTOR # 6423197	SSN 136-60-4317	GUARANTOR EMPLOYER SELF-EMPLOYED			
NAME RHODES JR, GEORGE HENRY		ADDRESS 1 507 S USSERY ST		ADDRESS 2	
ADDRESS 507 S USSERY ST		CITY/STATE/ZIP DOTHAN, AL 36301		DSCH	
PHONE 334 794-5424		PT REL PT		PHONE 334 794-5424	
PATIENT STATES: CR/NM/CHEST PAIN					
ADMITTING DIAGNOSIS: CR/NM/CHEST PAIN					
INS#1:	NAME	GROUP #	POLICY #		
INS#2:					
INS#3:					
COMMENTS: PRED BY COMP/011305 0936/PLW REG/PT SIGNED COT/ELL PT HAS INSURANCE DID NOT B					
RING CARD/ELL\$4599.50/					
PRINCIPAL & SECONDARY DIAGNOSIS					CODES
					DATE DICTATED
					D/S
PROCEDURES & OPERATIONS/DATES					H&P
					O.R.
					Cons

CONSULTATION WITH

PHYSICIAN SIGNATURE



Southeast Alabama Medical Center P.O. Box 6987 Dothan, AL 36302 334-793-8111

PRINTED BY: SAMC DATE 5/2/2005

#2049 Rev. 05/02

Southeast Alabama

**MEDICAL
CENTER****Graded Exercise Test (GXT)**

Patient Name: Rhodes, George MR No.: 400545 Acct. No.: 2542897 Date: 1/20/05
 Sex/Race: M, B DOB: 4/6/65 Weight: 163 Age: 39
 Family Physician: Dr. Miller Ordering Physician: Dr. Miller Testing Physician: Dr. Miller
 Predicted HR (max./90% max): 181 / 163 Predicted Time: 11:00
 Bruce Protocol: Modified Regular Isotope Card Drug Tech: Dr. Miller

Clinical Information: chest pain w/ SOB

Resting EKG: Medications: Atenolol 25mg qdPatient cannot walk on treadmill because:

Stage	MPH/Grade	Time	Rate	BP	Comments
Control sitting			102	110/64	
Standing					
0	1.7/0%				
1/2	1.7/5%				
1	1.7/10%	3	100	110/66	
2	2.5/12%	3	120	118/60	
3	3.4/14%	3	136	120/68	
4	4.2/16%	2	144	130/80	no ch
5	5.0/18%				Isotope Cardiolite 10:00 H.R. 144

Total Time: 11:00

Reason for Stopping: primary (1) secondary (2) tertiary (3)

chest pain: leg pain/fatigue hypertension: arrhythmia:
 dyspnea: general appear.: hypotension: HR achieved:
 fatigue: 2 cerebral symptoms: ST changes: other:

Risk Factors for ASCAD

HTN ☐ CVA/TIA ☐
 DM ☐ Claud. ☐
 Incr. Chol. ☐ Fam. HX. ☐
 Smoke ☒ No Risks ☐

POST EXERCISE

2 min post	3	93	104/70	
4 min post	3	78	104/70	
6 min post				

HR Achieved/% max: 144 / 80% Max SBP: 138/80 Rate X SBP (D.P.): 18,720Exercise Capacity: BP Response: EKG Response: INTERPRETATION: COMMENTS: Signed: Dr. Miller

Rhodes Jr. George
2542897

bottom edge of patient label

INFORMED CONSENT FOR GRADED EXERCISE TEST

In order to estimate how well my heart, lungs, and blood vessels perform, I hereby consent to perform a special exercise test at Southeast Alabama Medical Center. During the test I will walk on a treadmill or be given a drug to exercise my heart. My heart rate, blood pressure, and electrocardiogram will be recorded at different intervals throughout the test. I may request that test be discontinued at any time; otherwise, the supervising physician will stop the test on the basis of his observations if it is unnecessary or unwise to continue.

Every effort will be made to conduct the test in such a way as to minimize discomfort and risk. I understand this test carries no known risk for the patient with normal circulation. Persons who have heart disease are at some slight risk all the time, and this test briefly increases their risk of heart disease complications. Should I develop any symptoms such as leg cramps, weakness, light headedness, or chest discomfort, I will report such symptoms to the technician or the physician.

In addition, my physician may request that a radioactive element in solution for the purposes of heart scanning be administered intravenously as part of the exercise. This adds no additional risks to the exercise test and there are no known serious side effects from its administration.

Benefits from taking this test include the possibility of finding evidence that heart, lungs, and circulation are performing normally rather than limited by disease. If evidence of abnormality is found, the test data will contribute to identifying the nature and the extent of the abnormality as an aid to selection of the appropriate treatment.

Understanding the above, I do hereby give informed consent to the performance of a stress test in the Non-Invasive Cardiology Lab.

George Rhodes 1/20/05
Signature of Patient Date

Signature of Witness

Date

P.O. BOX 6987
WHAN, AL 36302-6987
CARDIOLOGY DEPARTMENT

Craven

CARDIOLITE REPORT

NAME: RHODES, GEORGE ROOM#: CR
MR#: 400545 ACCT#: 2542897
ATTENDING PHYS: L. DWIGHT BAKER, M.D. DOB: 04/06/1965
AGE: 39Y SEX: M

CLINICAL INFORMATION: CHEST PAIN

EXAM REQUESTED: 01/20/2005

DATE EXAM: 01/20/2005

REPORT: Radionuclide used: Cardiolite

REPORT: The patient exercised for a total of eleven (11) minutes on a Bruce protocol achieving a maximum heart rate of 144bpm. The patient had leg discomfort, but no chest discomfort. No E K G changes occurred. No arrhythmias were noted. Blood pressure response was normal with a peak blood pressure of 130/80, giving a double product of 18,720. Maximum heart rate was 144bpm., (80% of predicted).

The computer reconstructed SPECT Cardiolite images in the short axis, vertical long and horizontal long axis demonstrates normal Cardiolite uptake in all myocardial segments without evidence of a perfusion abnormality.

Review of the Gated images demonstrates normal L V size and systolic function with an estimated ejection fraction of 55%.

CONCLUSIONS:

- 1) Normal Cardiolite G X T.
 - 2) Normal L V systolic function.
- (B)

J. BEN CRAVEN, M.D.
CARDIOLOGIST

1

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cc: J. BEN CRAVEN, M.D. (01533)
L. DWIGHT BAKER, M.D. (07870)
MICHAEL E. PINSON, M.D. (08919)

>

/: 1533 DT: 01/21/2005 0216 DD: 01/20/2005 1754
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Authenticated by J BEN CRAVEN, MD On 1/25/2005 8:46:31 AM